EXHIBIT C - BIDDER CERTIFICATION AND ASSURANCES

Under the penalties of perjury of the State of Washington, we make the following certifications and assurances as a required element of our Proposal for RFQQ. We affirm the truthfulness of these facts and acknowledge our current and continued compliance with these certifications and assurances as part of our Proposal and any resulting contract award with DSHS.

1. We declare that all answers and statements made in the Proposal are true and correct.

2. We certify that the prices and/or cost data contained in our proposal: (a) have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition, and (b) have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before contract award, except to the extent that we have joined with other individuals or organizations for the purpose of preparing and submitting a joint proposal or unless otherwise required by law.

3. Our Proposal is a firm offer for a period of 180 days following receipt, and it may be accepted by DSHS without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-day period. In the case of a protest, the Bidder's Proposal will remain valid for 210 days or until the protest is resolved, whichever is later.

4. We have not been assisted by any current or former DSHS employee whose duties relate (or did relate) to this procurement and who assisted in other than his or her official, public capacity.

   If there are any exceptions to these assurances or we have been assisted, we will identify on a separate page attached to this document each individual by: (a) name, (b) current address and telephone number, (c) current or former position with DSHS, (d) dates of employment with DSHS, and (e) detailed description of the assistance provided by that individual.

5. We acknowledge that DSHS will not reimburse us for any costs incurred in the preparation of our Proposal. All Proposals become the property of DSHS and we claim no proprietary right to the ideas, writings, items or samples.

6. We acknowledge that any resulting contract awards will incorporate Special Terms and Conditions, Statement of Work, and General Terms and Conditions substantially similar to the sample contract attached to the procurement document.

7. We will comply with these or substantially similar Special Terms and Conditions, Statement of Work, and General Terms and Conditions if awarded a contract, and will negotiate in good faith any changes or modifications.

8. We acknowledge that if awarded a contract with DSHS, we are required to comply with all applicable state and federal civil rights and other laws. Failure to comply may result in contract termination. We agree to submit additional information about our nondiscrimination policies, at any time, if requested by DSHS

9. We certify that we have a current Washington Business License, and agree to promptly provide a copy of the license if we are awarded a contract.

10. We made no attempt, nor will make any attempt, to induce any other person or firm to submit, or not submit, a proposal for the purpose of restricting competition.

11. We acknowledge and authorize DSHS to conduct a financial Business Assessment and/or background check of our organization if DSHS considers such action necessary or advisable.

12. We acknowledge our obligation to notify DSHS of any changes in the certifications and assurances above.

_____

Signature

_____

Title

_____

Organization Name

_____

Date

CONTRACTOR BIDDER FORM

FREELANCE INTERPRETER BID

BIDDING

FIRST TIME/NEW BID	☐ YES ☐ NO
RENEW CONTRACT	☐ YES ☐ NO
CHANGE OF INFORMATION*	☐ YES ☐ NO

Change of information listed on this form must be reported by awarded contractors through submitting a new bidding form to ODHH within ten days of the change.

INTERPRETER INFORMATION

Interpreter Name	Social Security Number
Mailing Address	Date of Birth (MM-DD-YYYY)
Mailing City, State and Zip Code	County
Physical Address (if not same as Mailing Address)	
Physical City, State and Zip Code (if not same as Mailing Address	County

1st Telephone #: ( ) - Voice/TTY	☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax
2nd Telephone #: ( ) - Voice/TTY	☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax
3rd Telephone # ( ) - Voice/TTY	☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax
Email address:	☐ Home ☐ Work ☐ Pager
Email address:	☐ Home ☐ Work ☐ Pager
Website Address:	

AVAILABILITY

The sign language interpreter services are available as follows: (Check all that apply):

☐ Days; 8 am – 5 pm; Monday – Friday	☐ 24/7; 24 hours / 7 days every week
☐ Nights; 5 pm – 12 am; Monday – Friday	☐ Emergencies; 1 hour notice/confirmation
☐ Weekends; 12 am Sat – 8 am Monday	☐ Holidays

If providing Nights, Weekends, 24/7, Emergency interpreter services, provide contact information:

Telephone #: ( ) - Voice/TTY	☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

BIDDING BY REGION(S) / COUNTY(IES)

If bidding on entire region, indicate below by marking the space indicated for the entire Region;
If not bidding on entire region, indicate which county(ies) within region(s) you are bidding on below by marking the space indicated for individual county(ies); for bid region must be residing in that region.

Region 1 _____	Adams_____ Chelan_____ Douglas_____ Ferry_____ Grant_____	Lincoln_____ Okanogan_____ Pend Oreille_____ Spokane_____ Whitman_____	Region 2 _____	Asotin_____ Benton_____ Columbia_____ Franklin_____	Garfield_____ Kittitas_____ Walla Walla_____ Yakima_____
Region 3 _____	Island_____ SanJuan_____ Skagit_____	Snohomish_____ Whatcom_____	Region 4 _____	King_____	
Region 5 _____	Kitsap_____ Pierce_____		Region 6 _____	Clallam_____ Clark_____ Cowlitz_____ Grays Harbor_____ Jefferson_____ Klickitat_____ Lewis_____	Mason _____ Pacific_____ Skamania_____ Thurston_____ Wahkiakum_____

MINORITY WOMEN BUSINESS ENTERPRISE – OPTIONAL

- Purchasing goals from MWBE vendors for sign language interpreter services have been established.
- Are you a MWBE Bidder? ☐ YES ☐ NO If Yes, certification #_____ and attach a proof of certification copy. To obtain MWBE certification, contact OMWBE at (360) 753-9693

MINIMUM QUALIFICATIONS

- For freelance interpreter to be eligible to bid on this contract, bidding interpreter must:
- Be an RID or NAD certified interpreter and provide documentation of certification; ☐ YES ☐ NO
- Be able to provide sign language interpreter services with the competency and proficiency for each appointment; ☐ YES ☐ NO
- Have the ability to appropriately match communication needs of the customer with the interpreting skills and the appointment situation/setting; ☐ YES ☐ NO
- Be licensed to do business in the State of Washington; ☐ YES ☐ NO
- Be able to serve the entire county(ies)/region(s) that is/are bid; ☐ YES ☐ NO
- Have the ability to communicate as requested, with DSHS via telephone, email, facsimile, and/or pager and, if indicated, communicate during nights, weekends, holidays, and emergencies; ☐ YES ☐ NO
- Have the ability to provide advance confirmation of availability to interpret at appointments; ☐ YES ☐ NO
- Have the ability to immediately notify the requester if: unable to fill an appointment; going to be late; or cannot find a replacement; ☐ YES ☐ NO
- Be willing to obtain the required amounts of insurance, after contract award, as outlined in this RFQQ;
- ☐ YES ☐ NO

- Complete a Background Authorization Form; ☐ YES ☐ NO
- Be willing to register with ODHH; ☐ YES ☐ NO
- Be willing to sign and date ODHH registration form verifying all statements have been read, understood, and agreed to; ☐ YES ☐ NO
- Be aware of and adhere to the NAD-RID Code of Professional Conduct and the DSHS Code of Professional Conduct; ☐ YES ☐ NO
- Attend mandatory orientation; ☐ YES ☐ NO
- Be willing to comply with the Sign Language Interpreter requirements section in the Statement of Work; ☐ YES ☐ NO
- Comply with all specific requirements covered under this contract (General & Special Terms and Conditions and the Statement of Work; ☐ YES ☐ NO
- Have the ability to appropriately match the communications needs of the consumer with the interpreting skills and the appointment situation/setting; ☐ YES ☐ NO

This section includes specific requirements for HEALTH AND RECOVERY SERVICES ADMINISTRATION (HRSA) Medicaid appointments:

- Be willing to obtain a Provider Number. The necessary form will be provided at Orientation; ☐ YES ☐ NO
- Coordinate the appointment dates and times with the client as agreed to by the medical provider(s) and DSHS client; ☐ YES ☐ NO
- Be willing to follow HRSA's required procedures for calculating billing units; ☐ YES ☐ NO
- Be willing to indicate a Performing Provider Number (PPN) as an interpreter on the "Request for Sign Language Interpreter" form. A PPN will be assigned to the interpreter prior to payment by HRSA for services provided by the interpreter; ☐ YES ☐ NO

If you do not meet the above minimum qualification requirements, as stated herein, your bid will be rejected as non-responsive.

AGREEMENT

I understand I must register and be approved through the Office of the Deaf and Hard of Hearing before I can accept any interpreting assignments requested by DSHS administration(s)/division(s) to provide interpreting services.

☐ I certify that the information which has been provided is true to the best of my knowledge.
☐ I have read / understand the current NAD-RID Code of Ethics and agree to abide by it.
☐ I have read / understand the DSHS Code of Professional Conduct and agree to abide by it.
☐ I understand information will be on the DSHS website and Directory of Interpreters.
☐ I am a state employee and I am in compliance with DSHS Personnel Policy 531 "Employees Holding Outside Employment".

I understand that if any of the information provided above is found to be false, I may be prohibited me from providing services under this contract. This document is signed and sworn under penalty of perjury. I certify that the above information is true and correct.

Signature of Owner/Executive Director	Date (mm/dd/yyyy)

Washington State Department of Social & Health Services

Contractor Intake Instructions

All New DSHS Contractors must:

- Complete, sign and submit this form before a DSHS contract can be created.
- Complete and return a Request of Taxpayer Identification Number and Certification (W-9) before any payment for services will be made. A W-9 form is available at http://www.ofm.wa.gov/accounting/vendors/w9.doc

All Existing DSHS Contractors who have changed their business name/business organization, or experienced other significant changes, must complete, sign, and submit this form.

Section One: Contractor Name/Business Organization

1. **Contractor name.**
   - For an Individual or Sole Proprietor, enter your name as shown on your Social Security card on the "Name" line. Sole Proprietors provide Last Name, First Name, Middle Name, and Suffix.
   - Other entities. Enter your business name as shown on the legal document creating the entity.
2. **Business Organization.** Please mark only one.
   - If you are a nonresident alien foreign person or foreign entity, the IRS may require you to complete Form W-8.
   - If you are a Non-profit Corporation or a Faith-Based Non-Profit Corporation **attach a copy of your 501(c)(3) status**.
3. **Taxpayer Identification Number (TIN).**
   - Individual or Sole Proprietor - If you are a sole proprietor you may enter either your Social Security Number (SSN), or if you have one, your federal Employee Identification Number (EIN).
   - Other Business Entities - Enter the entity's Employee Identification Number (EIN). If the entity does not have an EIN, enter the SSN of the owner of the business.
   - Resident alien. - If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the SSN box.
4. **Default Reported, Fiscal Year, UBI Number, and Business License**
   - List any contracts that you have had with the state that have been terminated for default.
   - Provide your fiscal year end date.
   - Provide your Washington State Uniform Business Identifier (UBI) Number.
   - **Attach a copy of your State Master Business License**. You may be exempt from registering with the State of Washington if:
     1. Your annual gross income from activities in Washington State is less than $12,000;
     2. Your business is not required to collect or pay sales tax or use tax; and
     3. Your business is not required to obtain a license or registration from another Washington State agency.

Section Two: Contractor Primary Address Enter the primary address information of your business. If you are completing this form for a new DSHS contract, and you want to provide a contract-specific address in addition to your primary one, please do so in Section Five.

Section Three: Contractor Ownership Check those that apply to your organization. If you have a certification number, please provide that also.

Section Four: Contractor Contact Person(s) Enter the primary contact information for your business. If you are completing this form for a new DSHS contract, and you want to provide a contract-specific contact person other than your primary one, please do so in Section Five.

Section Five: Additional Information

1. **Contractor Additional Addresses.** If applicable, provide additional addresses used for DSHS Contracts.
2. **Contractor Additional Staff.** If applicable, provide additional staff information for DSHS Contracts. Additional staff may include those who have authority to sign a DSHS contract on behalf of the business, and are referred to as a signatory.

Section Six: Contractor Certification You must sign, date, and return this form before DSHS will issue a contract.

Washington State Department of Social & Health Services

Contractor Intake

Section One: Contractor Name/Business Organization **(DSHS staff enter on ACD Intake Detail screen)**

1. CONTRACTOR NAME

DBA OR FACILITY NAME

2. BUSINESS ORGANIZATION

- ☐ Individual or Sole Proprietor
- ☐ Non-Profit Corporation (**Attach a copy** of 501(c)(3) status)
- ☐ For Profit Corporation
- ☐ Faith Based (FBO) Non-Profit Corporation
- ☐ Faith Based (FBO) Unincorporated
- ☐ Governmental Entity
- ☐ Partnership
- ☐ Limited Liability Company, filing as a Sole Proprietor
- ☐ Limited Liability Company, filing as a Corporation
- ☐ Limited Liability Company, filing as a Partnership
- ☐ Foreign Person or Entity

If your business is **NOT** a sole proprietorship,
attach a list of the partners, members, directors, officers, and board members.

3. TAXPAYER IDENTIFICATION NUMBER (TIN)

Enter your TIN in the appropriate box.

- For individuals, this may be your Social Security Number (SSN).
- For other entities, it is your Employer Identification Number.

Social Security Number

_____ (Enter all 9 numbers, NO DASHES)

OR

Employer Identification Number

_____ (Enter all 9 numbers, NO DASHES)

4. DEFAULT REPORTED, FISCAL YEAR, UBI NUMBER, AND BUSINESS LICENSE

Have you had any contract with the state terminated for default? ☐ Yes ☐ No
If yes, **attach a list** of terminated contracts with an explanation why each contract was terminated.

Is your fiscal year end the same as the calendar year (January 1 through December 31)? ☐ Yes ☐ No
If the answer is no, what is your fiscal year end date? _____

What is your Washington State Uniform Business Identifier (UBI) Number? _____ (Enter all 9 numbers, NO DASHES)

Attach a copy of your current Washington State **Master Business License**.

If you do not have a Washington State Master Business License, explain below why you are exempt from registering your business with the State of Washington. (See page 1 for information on exemptions.)

Section Two: Contractor Primary Address **(DSHS staff enter on ACD Intake Detail screen)**

CONTRACTOR PRIMARY ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)

ADDRESS DESCRIPTION

CITY, STATE, AND ZIP CODE

EMAIL ADDRESS

COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)

PHONE NUMBER (INCLUDE AREA CODE)
( )

FAX NUMBER (INCLUDE AREA CODE)
( )

Section Three: Contractor Ownership Type (DSHS staff enter on ACD Intake Detail screen)

Do any of the following descriptions apply to your business? If so, please check those that apply.

	YES	NO	IF CERTIFIED, ENTER OMWBE CERTIFICATION NUMBER
Disadvantaged Business Enterprise	☐	☐	
Woman Owned Business Enterprise	☐	☐	
Minority Owned Business Enterprise	☐	☐	
Community Based Organization	☐	☐	

Section Four: Contractor Primary Contact Person (DSHS staff enter on ACD Intake Detail screen)

Primary contact person is a(n):

☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official

☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the primary contact person a current or former State Employee? ☐ Yes ☐ No
If yes, complete Ethics Certification enclosed with this form.

Is the primary contact person authorized to sign contracts? ☐ Yes ☐ No

PRIMARY CONTACT NAME	PHONE NUMBER (INCLUDE AREA CODE) ( )
FAX NUMBER (INCLUDE AREA CODE) ( )	PRIMARY CONTACT EMAIL ADDRESS
PAGER NUMBER (INCLUDE AREA CODE) ( )	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ( )

Section Five: Additional Information (DSHS staff enter on Intake Detail – Sub Information Summary screens)

1. ADDITIONAL CONTRACTOR ADDRESSES: IF YOU HAVE MORE THAN TWO ADDITIONAL ADDRESSES, YOU MAY **ATTACH** A LISTING OF ADDITIONAL ADDRESSES.

	ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)	ADDRESS DESCRIPTION
☐ Billing address ☐ Facility address ☐ Mailing address	CITY, STATE, AND ZIP CODE	

PHONE NUMBER (INCLUDE AREA CODE) ( )	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)
FAX NUMBER (INCLUDE AREA CODE) ( )	EMAIL ADDRESS

	ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)	ADDRESS DESCRIPTION
☐ Billing address ☐ Facility address ☐ Mailing address	CITY, STATE, AND ZIP CODE	

PHONE NUMBER (INCLUDE AREA CODE) ( )	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)
FAX NUMBER (INCLUDE AREA CODE) ( )	EMAIL ADDRESS

2. ADDITIONAL STAFF: IF YOU HAVE MORE THAN TWO ADDITIONAL STAFF (LISTED BELOW), WHO ARE ALSO RELEVANT TO YOUR DSHS CONTRACTS, PLEASE PROVIDE INFORMATION ABOUT THOSE STAFF ON A SEPARATE PAGE.

Additional staff person is a(n):

☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official
☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff a current or former State Employee? ☐ Yes ☐ No
If yes, complete Ethics Certification enclosed with this form.

Is the additional staff authorized to sign contracts? ☐ Yes ☐ No

Is the additional staff a contact for DSHS contracts? ☐ Yes ☐ No

ADDITIONAL STAFF NAME	PHONE NUMBER (INCLUDE AREA CODE) ( )
FAX NUMBER (INCLUDE AREA CODE) ( )	ADDITIONAL STAFF EMAIL ADDRESS
PAGER NUMBER (INCLUDE AREA CODE) ( )	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ( )

Additional staff person is a(n):

☐ Officer or Board Member ☐ Partner ☐ Staff Member ☐ Elected Official
☐ Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff a current or former State Employee? ☐ Yes ☐ No
If yes, complete Ethics Certification enclosed with this form.

Is the additional staff authorized to sign contracts? ☐ Yes ☐ No

Is the additional staff a contact for DSHS contracts? ☐ Yes ☐ No

ADDITIONAL STAFF NAME	PHONE NUMBER (INCLUDE AREA CODE) ( )
FAX NUMBER (INCLUDE AREA CODE) ( )	ADDITIONAL STAFF EMAIL ADDRESS
PAGER NUMBER (INCLUDE AREA CODE) ( )	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ( )

Section Six: Contractor Certification **(DSHS staff enter on ACD Intake Detail as Intake Form Date)**

You must sign, date, and return this form.

I certify, under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, and that I will notify DSHS of any changes in any statement.

SIGNATURE DATE	PRINTED NAME
	TITLE

ATTACHED SUPPORTING DOCUMENTATION CHECKLIST

☐ Copy of your W-9 - Request of Taxpayer Identification Number and Certification
☐ Copy of statement showing non-profit 501(c)(3) status (if applicable)
☐ List of partners, members, directors, officers, and board members (not applicable to sole proprietors)
☐ Copy of your Washington State Master Business License
☐ List of any contracts you have had with the state that have been terminated for default, including a brief explanation (if applicable)
☐ Ethics Certification (if applicable)
☐ List of Additional Addresses (if applicable)
☐ List of Additional Staff (if applicable)
☐ Copy of your Certificate of Insurance

EXHIBIT G – CONTRACTOR BIDDER FORM –PRICING SHEET

Contractor Bidder Form – Pricing Sheet

NAME OF INDIVIDUAL OR AGENCY_____ DATE (mm/dd/yy):_____

HOURLY RATES:

I/we propose to offer Sign Language Interpreter Services under this contract at the following rate(s)*:

National Association of the Deaf (NAD)	Registry of Interpreter f/t Deaf (RID)	National Interpreter Certification (NIC)	Non-Certified	Maximum Hourly Rate**	Interpreter Rates ***
Level V	SC:L, MCSC	NIC Master Interpreter	N/A	$55/hr	$____/hr
DeafBlind Rate	DeafBlind Rate	DeafBlind Rate		$58/hr	$____/hr
Level IV	CSC, CI and CT, RSC, CDI, CLIP-R	NIC Advanced Interpreter	QDI	$50/hr	$____/hr
DeafBlind Rate	DeafBlind Rate	DeafBlind Rate		$53/hr	$____/hr
Level III	IC, TC, IC/TC, CI, CT, OIC:C, OTC	NIC Certified Interpreter	N/A	$40/hr	$____/hr
DeafBlind Rate	DeafBlind Rate	DeafBlind Rate		$43/hr	$____/hr
N/A	N/A	N/A	Non-Certified	$25/hr	$____/hr
			DeafBlind Rate	$28/hr	$____/hr

CONTRACTOR SERVICE FEE

I/we propose to charge the following administrative fee per billable appointment per interpreter under this contract at the following rate, not to exceed $30**:

$_____ per billable appointment per interpreter

For emergency appointments, a $5 additional charge per hour will be added to the interpreter's hourly rate.

* DSHS will not award contracts to Bidders with exceeding the maximum rate limit.
** Bids must be rounded to a whole dollar figure. If DSHS receives a bid that is not rounded, DSHS will automatically round to the nearest dollar.
*** If contractor sub-contracts with freelance interpreters, rates paid to these interpreters must be on the price sheet. All bids with interpreter rates should be marked as proprietary.

EXHIBIT H – DSHS/ODHH FORM – SIGN LANGUAGE INTERPRETER REGISTRATION

Washington State Department of Social & Health Services

ODHH Office of the Deaf & Hard of Hearing

SIGN LANGUAGE INTERPRETER REGISTRATION

REGISTRATION	
YES	NO
☐	☐ First time/new registration
☐	☐ Renew annual registration
☐	☐ Change of information

Change of information listed on this form must be reported by submitting a new registration form to the Office of the Deaf and Hard of Hearing (ODHH) within 10 days of the change.

PERSONAL INFORMATION

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)

MAILING ADDRESS CITY STATE ZIP CODE — COUNTY

FIRST TELEPHONE NUMBER (INCLUDING AREA CODE)
( ) - Voice/TTY ☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

SECOND TELEPHONE NUMBER (INCLUDING AREA CODE)
( ) - Voice/TTY ☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

THIRD TELEPHONE NUMBER (INCLUDING AREA CODE)
( ) - Voice/TTY ☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

EMAIL ADDRESS
☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

EMAIL ADDRESS
☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

AVAILABILITY

I am currently employed or have a contract with the following Interpreter Referral Agency(ies) under which I will be providing interpreting services (check all that apply):

☐ EWCDHH – Spokane ☐ Dynamic Language - Seattle ☐ ASL Professionals – Tacoma

☐ NW Interpreters - Vancouver ☐ CSCDHH - Seattle ☐ Signing Resources - Vancouver

☐ Universal - Bellevue ☐ SignOn - Seattle ☐ Other: _____

☐ SEWSCDHH - Pasco ☐ ASL Interpreter - Seattle ☐ Other: _____

I am generally available on (check all that apply):

☐ Days; 8 a.m. – 5 p.m.; Monday - Friday ☐ 24/7; 24 hours / 7 days every week

☐ Nights; 5 a.m. – 12 a.m.; Monday - Friday ☐ Emergencies – one hour notice/confirmation

☐ Weekends; 12 a.m. Saturday – 8 a.m.; Monday ☐ Holidays

COMMUNICATION MODE

I predominantly use the following three (3) communication mode(s) ranked first through third (1, 2, and 3):

____ ASL ____ PSE ____ SEE ____ ORAL

____ Tactile/Closeup ____ Minimal Language ____ Other (specify): _____

SIGN LANGUAGE INTERPRETER REGISTRATION

CERTIFICATION

I am currently certified or will be certified. Check one (1) of three (3) options below:

☐ **OPTION ONE:** New NIC certificate issued by the Registry of Interpreters for the Deaf

My new NIC certification level is: _____ and I was certified on (mm-dd-yyyy): _____

I completed the knowledge, interview and performance tests. I attached a photocopy of my RID-NIC certification with my registration form.

☐ **OPTION TWO:** Certificates issued by RID and/or NAD.

My NAD certification level is: _____ and I was certified on (mm-dd-yyyy): _____

My RID certification level is: _____ and I was certified on (mm-dd-yyyy): _____

I attached a photocopy of either/both my RID/NAD certifications with my registration form.

☐ **OPTION THREE:** I am a non-certified sign language interpreter and will be taking the NIC knowledge, interview and performance tests. I am registering as a "non-certified" interpreter. I understand I must be certified within five (5) years from date of first time/new registration with ODHH regardless the awarding of any sign language interpreting contract at any given time. I attached three (3) reference letters from a deaf customer, a certified interpreter, and an agency with my registration form. I understand a representative of a DSHS agency cannot submit a reference letter.

RID Certification Maintenance Program (CMP):

My CMP cycle timeline begins on (mm-dd-yy): _____and ends on (mm-dd-yy): _____

As of June 30, 20 __ I have accumulated the following continuing education units (CEUs) in:

Professional Studies category (# of CEUs): _____

General Studies category (# of CEUs): _____

EXPERIENCE / SETTING

I started working in the interpreting profession on (mm-yyyy): _____

I am experienced and willing to interpret in the following settings (check all that apply):

☐ Mental Health
☐ Employment
☐ Legal/Court
☐ Platform
☐ K – 12 Education
☐ Children and Adult Protective Services
☐ Medical
☐ Business
☐ Administrative Hearing
☐ Performing Arts
☐ Post-Secondary Education
☐ Socio-Economic Benefits
☐ Drug and Alcohol
☐ Rehabilitation/Vocational
☐ Minimal Language Skills
☐ Deaf/Blind: Tactile or CloseUp
☐ Adult Education
☐ Law Enforcement
☐ Foreign Language (specify): _____
☐ Other (specify): _____

EDUCATION AND TRAINING

I was _____ years old when I started signing. My background in sign language started because (check all that apply):

☐ Parents, family members signed to me
☐ Deaf friend(s) signed to me
☐ Became involved with the Deaf community then learned to sign
☐ Took ASL/Deaf studies course(s) in high school
☐ Took ASL/Deaf studies course(s) in college
☐ Took ASL/sign language course(s) at: ☐ nonprofit serving deaf ☐ adult education ☐ private school

EDUCATION AND TRAINING (Continued)

I have a high school diploma or GED equivalent: ☐ Yes ☐ No

My background in education and training is as follows:

1. Have you **completed** an Interpreter Training Program (ITP)? ☐ Yes ☐ No If yes, give details:

NAME OF COLLEGE	TYPE OF ITP DEGREE	GRADUATION DATE (MM-YYYY)
	☐ AA ☐ BA ☐ MA	

2. Are you **enrolled** in an Interpreter Training Program (ITP)? ☐ Yes ☐ No If yes, give details:

NAME OF COLLEGE	TYPE OF ITP DEGREE	GRADUATION DATE (MM-YYYY)
	☐ AA ☐ BA ☐ MA	

3. Do you have a college degree (other than ITP)? ☐ Yes ☐ No If yes, give details:

TYPE OF ITP DEGREE	FIELD OF STUDY
☐ AA ☐ BA ☐ MA ☐ PHD	
TYPE OF ITP DEGREE	FIELD OF STUDY
☐ AA ☐ BA ☐ MA ☐ PHD	

DEMOGRAPHIC INFORMATION - OPTIONAL

1. Are you: ☐ Hearing ☐ Hard of Hearing ☐ Deaf
2. Do you have deaf family members? ☐ None ☐ CODA ☐ Sibling of Deaf Adult
   ☐ Other (specify): _____
3. Gender: ☐ Female ☐ Male
4. Ethnic: ☐ Caucasian ☐ African American ☐ Native American ☐ Asian/Pacific Islander
   ☐ Hispanic ☐ Other (specify): _____

SELF - DISCLOSURE

In this state or any other state, have you ever:

	YES	NO
1. Had your RID or NAD membership and/or certification lapse?	☐	☐
2. Had any substantiated allegations of a code of ethics violation pertaining to interpreting/transliterating practice by any certifying body or other agency?	☐	☐
3. Had you ever had an interpreter/transliterator Quality Assurance credential/state licensure denied, revoked or suspended?	☐	☐
4. Currently have any pending actions related to a denial, revocation, or suspension of any interpreter/transliterator credential / licensure?	☐	☐
5. Been convicted of a crime under any laws?	☐	☐
6. Currently have any criminal charges pending against you?	☐	☐
7. Found to have sexually assaulted, physically abused, or exploited a child or adult?	☐	☐
8. Found to have violated a protection order, restraining order?	☐	☐
9. Sanctioned by a disciplinary board (professional licensing board) or by agreed order had your license suspended, revoked or denied for sexual or physical abuse, neglect or exploitation of a minor or adult?	☐	☐

If you answer "Yes" to any of the questions above, please attach a letter explaining the circumstances in detail. Please be sure to provide the date, the state, and information regarding the crime and/or findings.

SELF – DISCLOSURE (Continued)

My signature on this registration form authorizes DSHS to review and/or obtain conviction records from the Washington State Patrol and other states; and to obtain from Washington and other states licensing information and any determination or finding of abuse, neglect or exploitation. I understand that the results of this background check will be kept in total confidence and may be released to or reviewed by DSHS when monitoring contract compliance. Any convictions or findings resulting after ODHH registration and approval shall be reported to ODHH within two working days. I have attached a copy of the Washington State Patrol self-background check and understand a copy has to be submitted to the awarded interpreter referral agency if I am an employee or sub-contractor.

REGISTRATION SUBMITTAL

I understand I must register and be approved through the Office of the Deaf and Hard of Hearing before I can accept any interpreting assignments requested by DSHS administration(s)/division(s) to provide interpreting services.

☐ I certify that the information which has been provided is true to the best of my knowledge.

☐ I have read/understand the current and revised RID Code of Ethics and agree to abide by it.

☐ I have read/understand the DSHS Code of Professional Conduct and agree to abide by it.

☐ I understand information will be on the DSHS website and Directory of Interpreters and that my social security number will not be published.

☐ I am a state employee and I am in compliance with DSHS Personnel Policy 531 "Employees Holding Outside Employment." A copy of the DSHS form (DSHS 03-023) or the appropriate Report of Outside Employment form is attached.

I understand that if any of the information provided above is found to be false, it may preclude me from providing services under this contract. This document is signed and sworn under penalty of perjury. I certify that the above information is true and correct.

SIGNATURE OF APPLICANT	DATE (MM/DD/YYYY)

REGISTRATION SUBMITTAL

Submit completed the registration form with original signature and the following required documentation by mail to:

- DSHS/ODHH Form – Sign Language Interpreter Registration
- Copy of RID/NAD Interpreter Certification
- Background Authorization Form
- State employees: "Report of Outside Employment" form, DSHS 03-023
- Non-certified interpreters: three (3) reference letters from one (1) deaf consumer; one (1) certified interpreter; and one (1) agency (non-DHSH customer).

Department of Social and Health Services

Office of the Deaf and Hard of Hearing

PO Box 45301

Olympia, WA 98504-5301

Washington State Department of Social & Health Services

ODHH Office of the Deaf & Hard of Hearing

Sign Language Interpreter Registration Renewal

REGISTRATION	
YES	NO
☐	☐ Renew annual registration
☐	☐ Change of information

Personal Information

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)

MAILING ADDRESS CITY STATE ZIP CODE — COUNTY

FIRST TELEPHONE NUMBER (INCLUDING AREA CODE)
( ) - Voice/TTY ☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

SECOND TELEPHONE NUMBER (INCLUDING AREA CODE)
( ) - Voice/TTY ☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

EMAIL ADDRESS
☐ Home ☐ Work ☐ Cell ☐ Pager ☐ Fax

Availability

I am currently employed or have a contract with the following Interpreter Referral Agency(ies) under which I will be providing interpreting services (check all that apply):

☐ ASL Professionals – Tacoma ☐ Language Fusion ☐ Sign Shares - Seattle
☐ Dynamic Language - Seattle ☐ NW Interpreters - Vancouver ☐ SignOn – Seattle
☐ EWCDHH – Spokane ☐ SEWSCDHH - Pasco ☐ Universal – Bellevue
☐ DSHS Independent Contractor ☐ Other: _____

Certification Maintenance

My certification has changed since my last registration with ODHH: ☐ No ☐ Yes

If Yes, my new certification is: _____. I received this certification on: _____. I have attached my certificate with the updated information.

RID Certification Maintenance Program (CMP):

My CMP cycle timeline begins on (mm-dd-yy): _____and ends on (mm-dd-yy): _____
As of June 30, 20 __ I have accumulated the following continuing education units (CEUs) in:

Professional Studies category (# of CEUs): _____

General Studies category (# of CEUs): _____

Declaration

I understand I must register and be approved through the Office of the Deaf and Hard of Hearing before I can accept any interpreting assignments requested by DSHS administration(s)/division(s) to provide interpreting services.

☐ I certify that the information which has been provided is true to the best of my knowledge.

☐ I am a state employee and I am in compliance with DSHS Personnel Policy 531 "Employees Holding Outside Employment." A copy of the DSHS form (DSHS 03-023) or the appropriate Report of Outside Employment form is attached.

I understand that if any of the information provided above is found to be false, it may preclude me from providing services under this contract. This document is signed and sworn under penalty of perjury. I certify that the above information is true and correct.

SIGNATURE OF APPLICANT	DATE (MM/DD/YYYY)

Registration Submittal

Submit completed the registration form with original signature and the following required documentation by mail to:

- DSHS/ODHH Form – Sign Language Interpreter Registration Renewal
- Background Authorization Form (DSHS 09-653)

Department of Social and Health Services
Office of the Deaf and Hard of Hearing
PO Box 45301
Olympia, WA 98504-5301

Washington State Department of Social & Health Services

BACKGROUND AUTHORIZATION

Please print clearly and use BLACK INK.

Instructions attached.

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1. NAME OF ENTITY REQUESTING BACKGROUND CHECK (REQUIRED)
Office of the Deaf and Hard of Hearing

2. NAME AND SIGNATURE OF PERSON REQUESTING BACKGROUND CHECK TO BE COMPLETED BY DSHS (REQUIRED)
PRINTED NAME: **Emily Hill, SLIM Program Manager** SIGNATURE:

3. PURPOSE OF BACKGROUND CHECK (REQUIRED ONLY FOR CHILDREN'S ADMINISTRATION, ECONOMIC SERVICES ADMINISTRATION (ESA), AGING AND DISABILITY SERVICES ADMINISTRATION (ADSA), AND DSHS STATE EMPLOYMENT)

CHILDREN'S ADMINISTRATION:
- ☐ Foster care
- ☐ Residential facility or child placing agency employee
- ☐ Adoption
- ☐ DCFS relative placement
- ☐ Subject involved in (or related to) CPS investigation

ESA:
- ☐ Family home child care
- ☐ Child care center
- ☐ School-age center
- ☐ In-home relative
- ☐ In loco parentis

DSHS STATE EMPLOYMENT:
POSITION NUMBER: _____ **(WRITE NONE IF NONE)**
- ☐ Permanent appointment
- ☐ Non-permanent appointment
- ☐ Student internship
- ☐ Work study
- ☐ Volunteer
- ☐ Layoff

ADSA:
- ☐ Subject involved in (or related to) APS investigation per RCW 74.34

4. BCCU ACCOUNT NUMBER (REQUIRED)
11003745

5. DSHS IDENTIFICATION (ID) NUMBER

SECTION 2. APPLICANT INFORMATION (COMPLETED BY PERSON TO BE CHECKED)

6. SOCIAL SECURITY NUMBER (OPTIONAL)

7. DATE OF BIRTH (MM/DD/YYYY) (REQUIRED)

8. PRINT YOUR COMPLETE NAME(S) (REQUIRED):

	LAST **(WRITE NONE IF NONE)**	FIRST **(WRITE NONE IF NONE)**	MIDDLE **(WRITE NONE IF NONE)**
A. CURRENT NAME:			
	(WRITE SAME IF SAME AS CURRENT NAME)	(WRITE SAME IF SAME AS CURRENT NAME)	(WRITE SAME IF SAME AS CURRENT NAME)
B. BIRTH NAME:			

9. PRINT OTHER LAST NAMES YOU HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)** (REQUIRED):

10. PRINT YOUR NICKNAMES AND OTHER FIRST NAMES YOU HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)** (REQUIRED):

11. **Have you been convicted of, or do you have charges pending for any crime?** (REQUIRED) ☐ Yes ☐ No
If yes, give the crime, state where it occurred, and the conviction date or charge status.
Attach additional pages if needed.
Crime: _____ State:_____ Conviction date: _____ Pending charge status:.... ☐ Yes ☐ No
Crime: _____ State:_____ Conviction date: _____ Pending charge status:.... ☐ Yes ☐ No

12. **Have you ever been found to have sexually abused, physically abused, neglected, abandoned or exploited a child, juvenile, or adult?** (REQUIRED) ☐ Yes ☐ No

13. **Have you ever had a contract and/or license to care for children, juveniles, or adults denied, terminated, revoked, relinquished, or suspended?** (REQUIRED) ☐ Yes ☐ No

14. **Has a court ever issued an order of protection against you for abuse, neglect, financial exploitation, domestic violence, or abandonment?** (REQUIRED) ☐ Yes ☐ No

15. LIST CURRENT DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER (REQUIRED)

(WRITE NONE IF NONE)	IDENTIFICATION NUMBER	STATE ISSUED

16. a. List present number of consecutive years and months you have lived in Washington State (REQUIRED): _____ Years/_____ Months
b. Have you completed a **DSHS** fingerprint check within the last three years? (REQUIRED) ☐ Yes ☐ No

17.

	STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
A. CURRENT (REQUIRED):					
B. PREVIOUS (OPTIONAL):					

18. I understand I am signing this statement under penalty of perjury. The above statements are true and complete to the best of my knowledge. I understand any untruthful or purposefully misleading answer or any deliberate omission may result in my immediate disqualification as an employee, provider, caretaker, licensee, contractor, and/or as an individual authorized to care for or as an individual with unsupervised access to vulnerable adults or children. I hereby authorize DSHS to obtain background information including but not limited to, convictions, licensing, child and adult protective services, and professional licensing records, from any law enforcement, any state and federal agency including other states and the FBI. I understand federal and state laws may require release of the results of this background check and any prior background checks in response to public disclosure request or civil discovery. I understand any incomplete or unreadable information may stop or delay processing, and my employment or contractual agreement is contingent upon successful completion and clearance of this background check.

19. SIGNATURE OF APPLICANT (REQUIRED)
IF APPLICANT IS LESS THAN 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN.

20. DATE (REQUIRED)
(VALID THREE MONTHS FROM THE DATE OF SIGNATURE)

FOR USE BY CHILDREN'S ADMINISTRATION AND DCCEL STAFF ONLY

CAMIS files checked by _____ on date _____ ☐ No information found ☐ Information

INSTRUCTIONS FOR COMPLETING THE BACKGROUND AUTHORIZATION FORM

This form must be completed as directed. No other form will be accepted.

The most common mistakes made when requesting a background check:

- Boxes are blank.
- Handwriting cannot be read.
- Wrong form is used.
- Applicant is less than 18 years of age and the parent or guardian did not sign the form.
- Date signed is older than three (3) months from the date received by the Background Check Central Unit.

SECTION 1: To be completed by the entity requesting the background check.

1. Required. List entity requiring background check. An entity may include a DSHS office, child placing agency, contractor, licensed facility, license applicant, provider, contracting agency, facility or home where care/service is provided, or parent. Contact the DSHS office you receive services from to find out what entity name should be listed.
2. Required. The person requesting the background check must print and sign their name.
3. Required **ONLY** for Children's Administration, Economic Services Administration, Aging & Disability Services Administration, and DSHS state employment.
4. Each DSHS office and entity required to conduct background checks through the Background Check Central Unit (BCCU) has an assigned BCCU Account Number. BCCU Account Numbers can be found at http://www1.dshs.wa.gov/msa/bccu/index.htm. Background check results are returned to the address or fax number associated with the BCCU Account Number. Please report any errors in address or fax number to BCCU at bccuinquiry@dshs.wa.gov or (360) 902-0299. Please include the BCCU Account Number in your email.
5. Optional. Many DSHS offices need an identification (ID) number to match results to DSHS clients, licensees, contractors, or DSHS offices and staff. An identification number may include, but is not limited to a parent or guardian's Social Security Number, client ID, DSHS worker ID, facility business ID. Contact the DSHS office you receive services from to find out if an identification number is needed.

SECTION 2: To be completed by the applicant (person to be checked). DSHS employees conducting an Adult Protective Services (APS) or Child Protective Services (CPS) investigation must complete this section to the best of their knowledge.

6. Optional.
7. Required.
8. A. Required.
   B. Required. Must include complete name at birth. Write SAME if birth name is the same as current name. Write NONE if you did not have a birth name.
9. Required. Write NONE if you are not known by any other name.
10. Required. Write NONE if you do not have a nickname.
11. Required.
12. Required.
13. Required.
14. Required.
15. Required. Write NONE if you do not have a driver's license or state identification number.
16. A. Required. If you have lived in Washington State for the past three (3) consecutive years but have an out of state driver's license, you may be asked to send your background form and proof of residency to the DSHS licensing or contracting office.

    Some applicants must complete a fingerprint card if they have not lived in Washington State for the past three (3) consecutive years. Contact the DSHS office you receive services from to find out if you need to complete a fingerprint card. **The Background Authorization form and fingerprint card must be sent together.**

    B. Required. If you have completed a DSHS fingerprint-based check within the past three (3) years and have not lived outside the state since the last fingerprint check, DSHS may use the previous result. Please mark the appropriate answer in Section 2, Box 16.
17. A. Required.
    B. Optional.
18. Read prior to moving to Box 19.
19. Required. If you are less than 18 years of age, your parent or guardian must sign this form.
20. Required. The Background Check Central Unit must receive the background authorization form within three (3) months from the date of the signature.

Washington State Department of Social & Health Services

ODHH Office of the Deaf and Hard of Hearing

BACKGROUND CHECK IDENTIFICATION VERIFICATION

Beginning date of employment, volunteer, or contractor/subcontractor status _____.

Photocopy of:
Driver's License, Identification Card, or U.S. Passport

(Document must be issued by a state or outlying possession of the United States, or by federal, state or local government agencies or entities (provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address.)

I am authorized to verify the true identity of the person named in the identification document(s). I have examined the original document(s) in the presence of the above person. The document above appears to be genuine and verifies the person.

I am verifying the identity as:

- ☐ A manager, director, owner, or board member of the organization as a DSHS Contractor.
- ☐ A designated employee of a DSHS Contractor authorized by management.
- ☐ A Notary Public currently licensed in the State of _____.
- ☐ An employee from the Office of the Deaf and Hard of Hearing.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
PRINT NAME HERE	TITLE

Send your completed form to Office of the Deaf and Hard of Hearing, PO Box 45300, Olympia WA 98504-5300.